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MENTAL ILLNESS: ITS EARLY SIGNS*

RÔLE OF THE FAMILY PHYSICIAN

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THERE is a fundamental difference between psychiatry and all other branches of medicine. A brief historical perspective leaves no doubt but that it was the suffering of the sick that created the primitive medical man, the ancestor of our present day highly-trained physician. Those who were physically sick never doubted their sickness, but loudly demanded help and relief from their pains, and the doctor had to respond and serve. From the earliest days of which we have record we find the doctor an idealized figure who, in turn, was expected to serve his patients with single-minded steadfastness and devotion.

When we turn to mental illness the historical picture changes completely. In the first place, the patient did not recognize himself as sick. A mind that is "lost" cannot surely be expected to take the lead in searching for itself. Moreover, he was often the first to insist that if any discrepancy existed between his ideas and those of the community, it was the latter who were unenlightened and out of step. The phenomena of mental illness were frequently so impressive that the baffled community was forced to concede the presence of supernatural powers, and delegated their religious authority to deal with those who were thus set apart from normal mortals. Thus began the insulation of the manifestations of mental illness from the inquiring but unhallowed touch of the scientist; and when, several milleniums later, the scientist first suggested that mental illness was a result of natural causes, he was met by terrific and passionate resistance to the point of persecution.

So it was that, whereas sickness created doctors, doctors working against the law of the State and the will of established religious faiths, created psychiatrists. This occurred only a few centuries ago, and the conquest of the field of mental disease by medicine is still far from complete. In no other field of disease is there such a preference for quackery in the form of "guidance" by amateurs, lay and clerical, and in no other field is it so necessary to refresh the thinking of the medi- Mark Twain's "damned human race," and he cal profession itself as to the aims and techniques of the group of specialists who are working in it.

In spite of the brief span of years during which mental illness has been considered a pathological entity, we are today faced with the somewhat paradoxical fact that our facilities for the care of these patients are being strained to the utmost. We can reduce this pressure on our mental hospitals by prevention, and by early diagnosis and treatment. As with chronic disease in general, early recognition will not only reduce the duration of treatment, but may obviate the need for hospitalization entirely. What has been said above by way of introduction, shows quite clearly why the burden of this task of early recognition falls, not upon the shoulders of the psychiatrist, whose practice is largely referred, but upon the general practitioner and family doctor. He is the one to whom patients and the families of patients, first bring their problems, and it is he who can take the initiative in bringing to the attention of patient, or family, the existence of mental illness. The family doctor sees his patients in their sickness and trouble over a period of years. He watches the children develop and notes the interplay between parents and children, and between the children and the world in which they live. People go to their doctors, not in order to demonstrate their strength and achievement but, rather, to confide their weakness and their failure. No one has a better chance than the physician to learn what lies behind dissimulation and the social mask. It is this type of relationship and the consequent wide knowledge of human nature which, should he be so inclined, qualifies the family doctor to recognize and deal with the early symptoms of mental illness.

BASIC CRITERIA OF MENTAL HEALTH

The basic criteria of mental health are simple and depend only upon common sense for their evaluation. They are these: Are the objectives for which the person is striving understandable, and in harmony with his personality, and are the means employed to bring about this end functionally effective, and economical? As with all simple criteria, they are much easier to state than to apply. In other words, they have the limitations of any measuring-rods applied to human nature; but surely there is no one better equipped than the experienced physician to use them competently and wisely. He is specially informed as to the vagaries of human nature, and knows that there are those of us who are steady and predictable from our earliest years, whereas others are eccentric or whimsical. He is less apt to look upon any given behavior as an isolated phenomenon, but will rather place it within the background of the total personality. He knows what may reasonably be expected of Johnny Johnson or Sammy Smith, when the one is apt to get into trouble or when the other may be expected to achieve success. He knows a good deal about

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knows about his individual patients as well. He can estimate the sum total of quirks and idiosyncrasies in his patients, and he knows that any sharp increase in the number of these indicates that something is afoot which may soon require special attention. If their actions are in accord with achieving what is for them a reasonable goal he need not be concerned; but if their actions are out of harmony with their potentialities, and no longer clearly effective and understandable in the light of the individual's personal history, the family physician is faced with the basic phenomenon of mental illness.

BEHAVIOR PROBLEMS OF CHILDREN

The clearest view of types of behavior which are abnormal can best be obtained by looking at the behavior problems of children. This is true not only because we all have a good idea of what to expect from any child of a given age but, also, because there is not a single symptom in the vast catalogue of psychopathology which does not have its roots in childhood and cannot be observed as a simply entity in the early years. The truth of the old adage that the child is father to the man is nowhere more forcefully exemplified than in the field of psychiatry. We must remember, however, that what may be a psychotic symptom in later years is not necessarily even abnormal in a child. It is a matter of degree and extent, and only when there is interference with the ordinary life of the child, or extreme concern on the part of the parents leading them to upset his usual way of doing things, do we speak of behavior disorder, or abnormality. While this warning may be pertinent in a psychiatric discussion, it is more usual to find that parents and doctors tend to minimize childhood maladjustments. In the hope that they will be outgrown, they are allowed to become fixed and progressively to handicap later development in increasing degree.

The most noticeable abnormal behavior in children is that characterized by a discrepancy between the type of action and what is ordinarily to be expected at a given age. We expect a baby to wet the bed, but not a 3-year old. We expect a 3-year old to attempt to trim the dog's ears with a pair of scissors, but not a 5-year old. We expect the 5-year old to ask to hear the old familiar story in preference to the new, but not the 9-year old. When we observe similar phenomena in adults, expressed in terms of goals and strivings, we speak of regression or fixation.

CLASSIFICATION OF BEHAVIOR DISORDERS OF CHILDREN

The behavior disorders of childhood can be broadly classified as those referable to the body and those referable to the outside world, the latter being what are known as social reactions. These disorders, with their derivatives and elaborations, constitute the symptomatology of adult life as well. So far as reactions referable to the body are concerned, we can name such as nail-biting, thumb-sucking, bed-wetting, failure in bowel training and body manipulations. These are the body attitudes which we find dominating the accounts of the childhood of the adult mentally-ill. The emphasis here should lie on the word "dominating," because all these reactions are also a part of normal development as well. The importance of degree takes precedence here over the importance of kind. It is only when these types of behavior become dominant and persistent, and interfere with development and the progression from one stage to the next, that they become of psychopathological importance. And a word of caution is appropriate here: all too often the suppression of a symptom, or unwanted type of behavior, is considered equivalent to eradication of the disorder itself. This is not the case. It is only when the symptom gives way to further developmental progress that it is eliminated; its suppression with the inevitable substitution by another, perhaps less obvious symptom, is not progress, but rather stagnation, and a mere postponement of the eventual settlement. All of these symptoms can be thought of in terms of time and energy wasted as well in terms of more elaborate theories of pleasure zones and psychosexual development; but the key to the problem is not the fact that they give gratification to the child, but that he desires this only in part. He himself is only too ready to forego whatever elemental pleasures may exist in these symptoms in favor of further development and the triumphs accompanying sublimation and achievement—provided he can find the road.

SYMPTOMATOLOGY OF SOCIAL REACTIONS

But let us turn to what we have referred to as the symptomatology of social reactions. Here we can name such behavior as withdrawal from the group, exaggerated dependence, inhibition of play, bullying, stealing, hates and resentments, and anxieties and phobias. Here again it is the degree of dominance and persistence that indicates the abnormal, rather than the particular content. And again we can say that it is not a preference on the part of the child that causes him to cling to the symptom. It is even more apparent here that even a minor triumph in the next developmental stage would be adequate compensation for relinquishing whatever pleasure might accompany the symptom. But it is again a question of finding the road. Whether dealing with children or with adults, it is safe to say that prohibition and correction serve no purpose. The problem of psychotherapy is always that of making available to the patient more adequate and more adult means of self-expression in terms of long-tested and socially acceptable modes. The patient who is completely trapped and deprived of adequate self-expression due to external limitations is probably nonexistent. In spite of what we have learned in recent years concerning the smallness of this globe whereon we exist, the

world is probably still a big enough place for the mature development of any one born into it.

This brings us back to the question of the purposefulness and usefulness of behavior, the economic attainment of an harmonious (egosyntonic) objective. This has been suggested as the criterion of mental health. One can see that it works out well when applied to these behavior disorders of children. It is also a therapeutic objective; but one can say very little concerning treatment in a paper designed to help the physician to recognize and understand these problems so that he can then apply his own common sense and experience to their solution. It is more profitable to go on to a brief consideration of the early symptomatology of mental illness in the period after childhood.

NEUROSES

The majority of mental cases that come to the attention of any doctor are the neuroses. The variety of clinical pictures presented are familiar to all of us. Once the physical health is assured the problem is to shift one's interest from the exaggeration and bizarreness of the complaints to the consideration of what they mean to the patient, and to the effect the illness has upon his successful functioning as a useful citizen. A surprising number of these milder mental illnesses find their way to hospitals eventually, and this outcome could often be prevented by sympathetic handling in the early stages, and by the patients being referred to a specialist at the moment it became obvious that symptoms were on the increase in spite of therapeutic efforts. The emphasis in recent years upon the psychosomatic concept in medicine has done much to help us realize that it is not the presence of gross, or microscopic, observable pathology that is important, but rather the functioning of the individual as a mind-body entity.

MANIC-DEPRESSIVE PSYCHOSIS

The family physician comes also into contact with the early stages of manic-depressive psychosis. The problem of recognition of mental illness is fairly simple here, but it is necessary to estimate correctly the extent of the illness and the speed of its progress. The manic phases move very rapidly, from the first indication that the patient's tremendous driving power is defeating his own ends to the point of helter-skelter activity with constant change of objective. The depressions move less rapidly, through minor complaints of mood change, insomnia, hypochondria and loss of weight, on to delusions and suicidal tendencies. The treatment in both types is essentially that provided by the mental hospital, but early recognition can markedly reduce the duration of illness.

DEMENTIA PRAECOX

The mental disease which fills far and away the largest proportion of hospital beds, and is also responsible for a great deal of economic failure, social unhappiness, and, also, many of our most sensational crimes, is dementia praecox, or what we have come to call the schizophrenias. The fact that the general public as well as the medical profession has become familiar with the descriptive, split-personality, does not make it any easier to recognize this disease in its early stages. The trouble is that these patients show so little upon which to base a diagnosis. The passive type, with his apparent lack of concern, or emotion, and the odd, impulsive type, with his emotional reactions out of proportion to the stimulus, are both difficult to recognize in their beginnings. But it is in just these cases that the criterion as to harmonious goal and effective action can be most helpful. The striking thing about the schizophrenic life-history is the apparent absence of understandable purposefulness in his behavior. Practically never do sensible goal and reasonable action coincide. Childish and even infantile behavior is prominent long before feelings of unreality and various types of hallucinations and delusions develop.

IN CONCLUSION

At the beginning of this paper I spoke of the difference in origin between psychiatry and the rest of medicine. There are other differences as well. One of these is the fact that pain, or fever, or a bleeding wound are known to all men. The doctor can identify directly with the suffering patient, and treat him with tenderness and sympathy. But to identify with and similarly treat a patient with mental disease requires a special psychological set. Every mental patient presents an inability or unwillingness to fit in with our social organization and could be considered either a rebel or a weakling. In fact the tendency so to consider him is something which must be overcome if one is to achieve the identification with the patient without which treatment cannot succeed. Another big difference between medicine and psychiatry is the fact that the former could take over directly the tools of physics and chemistry, and apply them to its progress. Psychiatry has had to forge its own tools and against inner as well as outer resistance. The insecurity of this position is obvious. We psychiatrists feel that we have the right to ask those who created us, the physicians in the other branches of medicine, to support us in our difficult task. We are more than pleased when we find other physicians interested in our work, and we shall do all in our power to increase this interest and to demonstrate the possible rewards in terms of community health which we believe our specialty to promise.

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The wise man will live as long as he ought, not as long as he can. . . . He always reflects concerning the quality, and not the quantity, of his life.

—Seneca, *Epistulae ad Lucilium.* Epis. lux, 4. Quoted by Montaigne, *Essays.* Bk. ii, ch. 3.